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Health Insurance Under the Affordable Care Act

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Who's eligible and what the law requires of insurers and plans

Very soon many Wisconsinites will enter the Health Insurance Marketplace (also known as the "Health Care Exchange") to obtain their health insurance. There are several important Affordable Care Act (ACA) rules they should be aware of, which are described below.

First, to be eligible for health insurance on the Marketplace, the individual must:

- Be a U.S. citizen or a lawfully-present non-citizen.
- Not be incarcerated.
- Live in a Marketplace's service area.

Second, health insurance rates may only vary from individual to individual because of the following:

- Tobacco use
- Geographic region
- Age (but only to three times the initial rate)
- Self-only or family premiums

Third, more information about specific insurance rates and an individual's ability to qualify for subsidies or BadgerCare is expected to be released in the next few months. For example, to qualify for BadgerCare in 2014, a non-pregnant adult must have a modified adjusted gross income (MAGI) under 100% of the federal poverty level. DHS is expected to release the MAGI formula on November 18, 2013.

Next, health insurance companies can no longer do any of the following:

- Deny insurance because of a preexisting condition (children now and adults in 2014)
- Set lifetime dollar limits on care
- Set annual dollar limits on care (effective 2014)
- Drop coverage if an individual gets sick
- Charge women more for coverage

Health insurance companies may terminate coverage if the premiums are not paid or if the person was untruthful on the insurance application. More information will be provided on payment-related issues at a later date.

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Under the ACA, health insurance companies are also required to:

- Justify publically any premium increase of 10% or more.
- Spend premiums prudently. Generally, insurance companies will be required to follow the "80/20" rule. This rule requires 80% of the premium dollars to be spent on health care and 20% on administrative costs.

Lastly, all marketplace health insurance plans must offer certain "essential benefits." Those essential benefits include the following:

- Pediatric services
- Emergency services
- Hospitalization
- Ambulatory patient services
- Maternity and newborn care
- Preventative and wellness services
- Chronic disease management
- Laboratory services
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services

These essential services are the minimum a qualified health plan (QHP) must provide. Insurers may choose to provide additional services. As the federal review of insurers is not complete, specific information about the available plans is not yet available.

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